Discharge and Service Termination Appeals

Requesting a review of a hospital discharge notice or other notice of non-coverage

Livanta is a Medicare Beneficiary and Family Centered Care - Quality Improvement Organization (BFCC-QIO) providing Medicare case reviews in 27 states and U.S. territories. As a BFCC-QIO, Livanta reviews thousands of hospital discharge and service termination appeals every week. Beneficiaries and their families and representatives file these appeals when the provider gives them a notice that it is now time to move to a less intensive care setting, such as from hospital care to skilled nursing facility (SNF) care or from SNF care to custodial care, assisted living facility care, or even home care.

When a Medicare beneficiary, family member, or other representative files an appeal, Livanta requests a copy of the medical record from the healthcare provider. Once received, the medical record is reviewed by one of Livanta's independent physician reviewers. The purpose of this review is to determine whether the beneficiary can safely be transitioned to a less intensive care setting. As a Medicare BFCC-QIO, Livanta must follow Medicare's rules and requirements for the beneficiary appeals process.

Livanta has prepared this document to help Medicare beneficiaries and their families understand the appeals process and their rights under that process. The information below is meant to be general guidance for common situations.

Section 1: Appeals - General Questions

1. **I received a Notice of Medicare Non-Coverage (NOMNC) or the Important Message from Medicare (IM). Does this mean I am expected to be discharged home with no further medical services?**
   Usually not. When beneficiaries receive a NOMNC or IM, it does not mean that they will no longer be entitled to medical care or that they will be abandoned. Instead, receiving this type of notice means that your healthcare provider or your managed care organization thinks it is time to move to a less intensive level of care, such as from a hospital to a skilled nursing facility (SNF) or from a Part A SNF (daily skilled services) to Part B intermittent services (up to 3 days per week) at an extended care facility, at a custodial facility, or through home health services to continue any needed medical services.

2. **I am a relative or friend of the Medicare beneficiary. Am I allowed to file an appeal?**
   Yes. An appeal may be filed by the beneficiary or the beneficiary's representative. However, for Livanta to share confidential information with the beneficiary's representative, the beneficiary must appoint a representative. This can usually be done by having the beneficiary designate a representative using Form CMS-1696, a Power of Attorney form, or a similar document. In urgent circumstances, the BFCC-QIO can accept appeals from family members who can certify that he or she is the Medicare beneficiary's caregiver even without an official form.

3. **I obtained a copy of the medical record that my healthcare provider submitted to Livanta, and it contains some inaccuracies. What can I do?**
   You can work with the facility to get the record corrected. If the facility does not agree to changes, you have the right to submit a statement to the healthcare provider. This statement can dispute or supplement any item in the medical record. You can also submit this statement to Livanta during its review and/or to the adjudicator of a further level of appeal. The statement must also be included by the provider with the rest of the medical record for future requests of the medical record. The Office of Civil Rights (OCR) of the Department of Health and Human Services enforces this right. The OCR can be reached at 800-368-1019.

4. **Will Livanta interview me, my attending physician, or my family before making an appeal decision?**
   No. Under its contract with the Medicare program, Livanta must base its appeal determination on the medical record, although the independent physician reviewer will also read letters and notes submitted with the appeal, whether they are from the Medicare beneficiary, doctors, family members, or others. The most persuasive evidence is the medical record, but having the written opinion of other medical professionals, the Medicare beneficiary, family members, or others addressing why a transition to a less intensive level of care is not appropriate can be helpful.

5. **Why is the appeal decided so quickly?**
   Under the law and regulations and its contract with Medicare, Livanta must make its initial appeal decision within 24-72 hours.

6. **How will Livanta ensure a fair and objective review of my case?**
   Livanta and its independent physician reviewers are not evaluated or paid based on the outcome of a case review. Also, Livanta's staff and physician reviewers are not permitted to have conflicts of interest. Potential conflicts are formally reviewed to ensure that each case is handled by staff and reviewers who are not personally familiar with the respective healthcare provider. Thus, Medicare beneficiaries should be reassured that their case review determination is objective and not subject to influence.

7. **What if I am OK with my discharge or service termination, but I still need help with a related or unrelated problem with my care?**
   Livanta provides an immediate advocacy service for Medicare beneficiaries who are having problems, difficulties, or other concerns with their care. Immediate advocacy helps resolve many problems in real time, including discharge issues. For FAQs about Livanta's immediate advocacy service, click the link below.

   - FAQs Immediate Advocacy: https://www.livantaqio.cms.gov/assets/files/Advocacy-FAQs.pdf

Section 2: Skilled Nursing Facility (SNF) Service Termination Appeals

1. **When I go into a skilled nursing facility (SNF) after a 3-day stay in a hospital, how long am I entitled to stay there? I heard it was 100 days.**
   To qualify for SNF care, the Medicare beneficiary must have a qualifying 3-day hospital stay. This rule requires that the beneficiary's status during their hospital stay is "inpatient"—not observation or outpatient status. If the 3-day inpatient requirement is met, Part A of Medicare allows for up to 100 days of daily skilled nursing (7 days per week) and/or daily (5-days per week) skilled therapy (physical therapy, occupational therapy, and/or speech therapy) as long as four conditions are continuously met. Once any one of these conditions is no longer met, Part A coverage must end. The four conditions are:

   a. The patient requires skilled nursing services or skilled rehabilitation services, that is, services that must be performed by or under the supervision of professional or technical personnel, are ordered by a physician, and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he or she received inpatient hospital services.
   b. The patient requires these skilled services on a daily basis. (This means 7 days a week for skilled nursing and 5 days a week for therapy.)
   c. As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis.
   d. The services delivered are reasonable and necessary for the treatment of a patient's illness or injury. This means that services are consistent with the nature and severity of the patient's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

2. **Do I have to be getting better to continue getting coverage for Part A skilled services in a skilled nursing facility (SNF)?**
   No. Improvement is not a requirement for Part A SNF services to be covered. Such services are available so long as the four requirements mentioned in FAQ #1 are met, even if the result is only maintaining the patient's condition and preventing decline.

3. **If I am in a skilled nursing facility (SNF) and the doctor sends me to the hospital for three days, and I come back to the SNF, does my 100-day maximum stay start all over again?**
   Possibly. If the condition that sent you back to the hospital is a new illness or injury, then the 3-day hospital stay qualifies you for up to 100 days in the SNF for the new illness or injury. If, however, the treatment at the hospital is related to the original hospital stay, then the original 100-day maximum still applies.

4. **If I lose the appeal at the BFCC-QIO, can I still get Medicare-covered skilled therapy in the same facility?**

If the facility agrees, you can transfer to custodial service and receive Part B therapy. Part B therapy is the same as Part A therapy, but on a less intensive basis, usually up to 3 times a week instead of daily (5 days a week). However, when receiving custodial services, costs for room and board are the patient's responsibility. In addition, deductibles and coinsurance may apply to the Part B therapy.

5. **If I am discharged from the SNF, can I still get Medicare-covered services?**
   Yes. Skilled services, including therapy, can still be covered by Medicare at home or in other facilities such as extended care or assisted living facilities.

Section 3: Hospital Discharge Appeals

1. **How long am I entitled to stay in the hospital with Medicare Part A coverage?**
   Once a Medicare patient is properly admitted to inpatient hospital services under Part A, there are usually three things that must happen before discharge:

   a. Medical personnel at the hospital or managed care plan determine that the acute nature of the illness or injury has passed and that the patient has stabilized to the point of being able to be moved safely to a less intensive level of care to continue recovery.
   b. A safe and effective discharge plan is in place to transition the patient to the next level of care.
   c. The patient is timely given the "Important Message from Medicare" (IM) and exhausts the appeals process.

The FAQs above are educational only and are not legally binding on Livanta, on a Medicare beneficiary, or on the Medicare program.

This material was prepared by Livanta LLC, the Medicare Beneficiary and Family Centered Care - Quality Improvement Organization (BFCC-QIO) that provides claims review services nationwide and case review services for Medicare Regions 2, 3, 5, 7, and 9, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 12-SOW-MD-2023-QIOBFCC-BENE82